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Original Articles.

TWO CASES OF AMPUTATION AT SHOULDER-JOINT IN WHICH WYETH'S PINS, TO CONTROL HEMORRHAGE, WERE USED.[1]

By JOHN H. BRINTON, M.D.,

PHILADELPHIA.

CASE 1. *Osteitis deformans of the leg, followed at the expiration of twenty-three years by sarcoma of the humerus; amputation at shoulder-joint by the oval method; use of Wyeth's pins to control hemorrhage; death on the tenth day:*—E. B., aged forty-eight years; born in Massachusetts; publisher. About twenty-three years ago he noticed tenderness over the right tibia, increased by pressure, by severe or prolonged exercise, and by barometic changes. Various anti-rheumatic measures were employed, but without avail. The limb did not become much worse; he was able to be about and follow the business of his life for years. During this time he was not lame, but experienced a sense of weakness in the limb. To use his own expression, "he favored that leg." In the course of years the bones of the leg had gradually increased in thickness, and had become curved. About ten years ago he consulted the late Prof. Agnew, who told him that he could do nothing to relieve his slight disability of the limb, and that the affection was incurable. About three years since he consulted me, but I could add nothing to what had been already said, and could suggest no treatment.

In November, 1891, the patient consulted me for a fractnre of the body of the left scapula. This resulted from a fall backward, as he was descending from the step of a railroad car, the scapula striking the edge of a projecting board or plank. This fracture healed rapidly and well.

In June, 1892, in jumping from a street car while in motion, and while his hand grasped the railing, he experienced great pain just below the right shoulder, and felt that the arm was broken. He came directly to my office. On examination, I detected crepitus, diagnosticated fracture of the anatomical neck of the humerus, and treated him for that injury. Union took place quickly, and full use of the limb was obtained. The only noticeable feature in this injury was the

[1] Read before the Philadelphia Academy of Surgery, April 8, 1893.

occurrence of slight pain referred to the outside of the humerus, about the lower portion of the upper third. There was at that time no enlargement of the bone at this locality.

On September 19, 1892, the patient again consulted me, stating that a "lump" had appeared on the outside of the humerus at its upper part. I examined the arm and found distinct cylindrical enlargement of the humerus, obviously a sarcoma of the bone, and I stated this to the patient, advising him to consent to the removal of the limb at the shoulder-joint, if the diagnosis should be confirmed by a preliminary incision. At the patient's request, Drs. Packard and John Ashhurst saw the case in consultation, and they agreed with me in the propriety of immediate operation. From a careful examination of the patient's entire clinical history, there was no doubt in our mind that the case was one of osteitis deformans, first described by Paget, and which had been followed, as is so often the case, by the development of a malignant growth.

The operation was fixed for October 5, 1892, but at the preliminary shaving of the axilla, and preparation of the limb, or by the patient's lifting of the limb, fracture, which may fairly be regarded as spontaneous and non-traumatic, occurred, as was made evident at the time of operation, done in the presence and with the assistance of Drs. Keen, Ashhurst, Packard, and others.

To prevent hemorrhage, the long steel pins of Prof. Wyeth were inserted by Dr. Keen, the anterior one transfixing the anterior axillary fold in front of the vessels, penetrating the tendon of the pectoralis major muscle, and emerging near the end of the acromion.

The posterior needle pierced the deltoid and emerged just below the acromion. By carrying the needle, especially the anterior one, well upward, the constricting rubber band was placed so high as not to prevent the rotation of the humeral head, or to interfere materially with its disarticulation.

This patient suffered very slight loss of blood at the time of the operation, and received but little shock. He reacted promptly and perfectly, and for several days did well, the wound uniting throughout. On the night between the fifth and sixth day the temperature rose to 104.5°, and a copious eruption, similar to that of measles, appeared on the abdomen and chest, and eventually invaded the extremities, and indeed the whole body. There was marked coryza, and the tongue became brown and dry.

This condition resisted all treatment and the free use of antipyretics. As the eruption spread, the temperature still rose, reaching 107.5° and 108,° and the patient died on the afternoon of the 15th of October, the tenth day after the operation. The intellect remained clear until within an hour or so of the end.

I cannot but regard the death as due to some form of septic infection not easy to determine.

It is unnecessary to add that the antisepsis was observed in the treatment before, during, and after the operation.

The specimens, showing the sarcoma of the shaft of the humerus, and the peculiar indented fracture of its head and anatomical neck, are before this Academy. I particularly desire the observation of the Fellows to the fracture, which appears to me to have resulted from violent impact of an infiltrated diseased caput humeri against the edge of the glenoid cavity.

CASE II.—*Amputation at shoulder-joint for enchondroma of humerus.*—The other case of shoulder amputation, in which I used Wyeth's pins, was that of a boy (I. B.), from Vermont, ten years of age. Nearly a year previously a tumor, apparently an enchondroma, began to develop on the inner side of the humerus, close to the head of the bone. It eventually grew until it attained a diameter of two and a half inches. It was painless, but interfered with the joint-motion by its bulk. The boy was brought to the clinic of the Jefferson Hospital, and after consultation with my colleagues, I determined to remove the arm at the shoulder.

This was accordingly done on the 28th of November, Wyeth's pins being first introduced by my colleague, Professor Keen. The anterior pin was made to emerge three-quarters of an inch above the tip of the acromion. As a result the circular turns of the tubing rested on a somewhat higher level than in the preceding case. Perfect freedom of the joint was preserved, and its disarticula-

tion was not unimpeded. Previous section of the bone with the saw, as directed by Professor Wyeth, was not necessary. A roller bandage was applied as a compress under the tubing and directly over the artery. Hemorrhage was thus perfectly prevented, and the removal of the limb, as in the former case, was practically a bloodless procedure. This boy recovered without accident.

I may state that in both these instances an Esmarch elastic bandage was applied previous to the insertion of the pins.

DISCUSSION.

Dr. William W. Keen: I would call attention to the control of hemorrhage by Wyeth's method. This afforded perfect hæmostasis. I never saw anything better, and as compared with the method which I devised myself a few years ago, by a compress over the subclavian artery, I think that it is vastly superior. In the first of Dr. Brinton's cases the pins were brought out at the end of the acromion process, and when the head of the bone was removed the skin slipped down and the constriction of the tube partially obliterated the cavity where the head of the bone had been. In the second case, the pins emerged three-fourths of an inch from the tip of the acromion, and there was no trouble from the slipping of the tube downward.

Dr. John B. Deaver: How much blood was lost in these cases?

Dr. Brinton: In the first case there was a little blood lost on account of the slipping of the rubber tube—perhaps two ounces. In the second case there was practically no blood lost.

Dr. Deaver: I have had no experience with the Wyeth pins in amputation at the shoulder joint. I have relied upon good assistance and have never seen much bleeding. There is no doubt that the method described is an excellent one, and the only question in my mind was whether the presence of the tube did not interfere with the manipulation in disarticulating. In the few chronic cases on which I have operated all have recovered.

Dr. James M. Barton: Unless there is some tumor encroaching upon the joint, interfering with the manipulation, I am in favor of an assistant grasping the artery as the flap is divided. Some years ago I saw a case of large sarcoma of the head of the humerus perish from hemorrhage on the table. The pins under such circumstances would have saved life.

Dr. W. W. Keen: I think that there is no possible doubt that the tube does not interfere with the manipulations, but that it assists us in making them. You have absolute confidence in your hæmostasis which you cannot have in any assistant whose arm or thumb is apt to get tired.

Dr. H. R. Wharton: I have not had any experience with Wyeth's pins in shoulder-joint amputation, but I can see how the method should be very useful, although I have not seen much bleeding where they have been good assistants. In my experience the most blood has been lost in the preliminary incisions. The only point would be in regard to the interference with the disarticulation if the tube slipped. I have seen Dr. Agnew use a pin under the vessels with a ligature above, which controlled the hemorrhage very satisfactorily.

The President: Some years ago I used the Esmarch tube in the of a figure of eight in amputation at the shoulder-joint with perfect success. An assistant held it up when there was any tendency to slip.

ENTERECTOMY FOR OBSTRUCTIVE EPITHELIOMA AT THE ILEO-CÆCAL VALVE. SECONDARY ANASTOMOSIS. OPERATION BY ABBE'S LONG INCISION.

By JAMES M. BARTON, A. M., M. D.
[Surgeon to the Jefferson College Hospital and to the Philadelphia Hospital.]

I SAW Mr. B. for the first time, on April 18, 1892, at Millville, N. J., in consultation with Drs. Smith and Newell. He was in bed, was very pale and thin, and had frequent attacks of sharp pain while we were talking to him. I obtained the following history. He was twenty-seven years of age, and had been in his usual health until the first of January, when he had an attack, similar to the present one, lasting one week. From then until the latter part of March he was able to attend to his work in the glass house, but was troubled with some pain and considerable tenesmus. He went to the water closet from four to eighth times daily, passing, with difficulty, a few small scybala each time. His constipation increased until four

weeks ago he had several attacks of complete obstruction, each lasting four or five days, and only relieved after taking many purgatives.

He now has and has had for the last two weeks about four diarrhœic passages daily. He has severe attacks of cramp in the right iliac fossa every few minutes, requiring the constant use of large doses of morphia. These attacks are accompanied by a half inch elevation of the abdominal walls over the painful point. As the pain leaves, the abdominal wall descends, and gurgling of wind is heard and felt. He has been confined to his bed for two weeks and is greatly exhausted. There is no elevation of temperature, no tenderness on pressure, and there is no tumor felt, though carefully searched for. There has been no vomiting at any time.

From the absence of vomiting and the marked tenesmus present, I regarded the obstruction as being in or near to the beginning of the large bowel; that it was not far from the ileocæcal valve was shown by the elevation of the abdominal wall at this point by the obstructed gas. The diarrhœa was an evidence of an intussusception, and the very short time the symptoms had existed, and the very complete obstruction present, pointed to a malignant growth as the cause of the intussusception.

Two days later I again visited Millville for the purpose of removing the growth. I was assisted by Drs. Newell and Smith, of Millville; Dr. Jones, of Camden; and Mr. Borsch, a student at Jefferson College. An incision about three inches long was made in the right iliac fossa, similiar to the incision made in removing the appendix. On introducing the finger the growth was found at once. The intussusception could not be reduced as the epithelioma had grown since it had occurred. After incising the bowel to verify the diagnosis, I removed about six inches of the intestine, including the obstructing epithelioma. Preparations had been made to perform lateral anastomosis at once, but the patient was so severely shocked that the operation was terminated by a temporary artificial anus.

He recovered without difficulty, gaining rapidly flesh and strength, and came to me, in Philadelphia, in June, to have the anastamosis operation performed. I placed him in a private room in the Jefferson College Hospital, and on the 16th I operated, assisted by Drs. Ashton, Fisher, Mr. Borsch, and the house staff. My purpose was to make a long opening by the method devised by Dr. Abbe, between the lowest possible portion of the ileum and the highest and most convenient portion of the colon; to permit the artificial anus to remain as a safety valve and only close it after the anastomosis opening worked satisfactorily. In order to determine where to make my incision, probed the bowel at the artificial anus, some days before the operation, and with various sounds and catheters, and found it ran directly across the abdomen to the left iliac fossa. As I could not hope to join this to the acending colon, I decided to use either the transverse colon or the sigmoid flexure, and to open the abdomen by a short incision to the left of the left rectus, as being within reach of both these portions of the large bowel and directly over the portion of the small bowel I wished to use but far enough from the artificial anus to escape the risk of infection. This was an error, the incision should have been made in the median line, rather higher than I did make it and long enough to get a fair view of the intestines.

Just before opening the abdomen I introduced a sound into the artificial anus, so that I might be able to verify, without delay, the portion of the ileum I wished to use after the abdomen was opened.

A three-inch incision was made about two inches to the left of the median line and parallel with it, ending just above Poupart's ligament. The ileum, with the bougie in it, was readily identified, and as the transverse colon hung well into the wound, the sigmoid flexure was not searched for. After stripping the portions of the bowel I intended to use of their contents, and preventing their return by a temporary rubber ligature, the ileum and colon were laid side by side and joined by a line of suture five inches long; when completed the needle was removed and the unused thread permitted to remain. A second line of suture, four and a half inches long, parallel and close to the first, was introduced,

and the unused threads were also permitted to remain.

Both bowels were then opened by a four-inch incision about a quarter of an inch from the last suture. A third suture was used to join the edges together, passing each stitch across the freshly divided edges so as to check the bleeding. This stitch is known among seamstresses as a "whipping stitch." The pliability of the intestines is such that not only the distal edge can be so closed, but a large portion of the edge on the side of the incision toward the operator. A needle was now placed on the unused thread attached to the second line of suture, and this was continued around the ends and in front of the opening, joining the intestines together at about a quarter of an inch from the opening and parallel to it. This suture, when completed, entirely surrounds the opening, and is about a quarter of an inch from it. Lastly, the unused thread of the first suture, which was still hanging at the end, has a needle put on it, and it is carried around the ends and in front of the opening. This suture when completed also surrounds the opening and is about half an inch from it.

The operation can be quite rapidly performed, the intestines being held in contact, by an assistant. After the first line of stitching is made it is still easier, and the suture can be made nearly as fast as the same operator would sew a seam in muslin.

The whole operation was performed with a constant stream of tepid boiled water flowing over the intestines we were joining together. As soon as the stitching was completed the intestines were replaced in the abdominal cavity, which was thoroughly flushed, and as the sutured intestines laid in position without undue strain, the abdomen was closed.

The slight vomiting after the ether soon ceased. A number of ounces of fecal matter passed from the artificial anus, but less than before the operation. At the expiration of twenty-four hours there was occasional regurgitation of fluid from the stomach and when I saw him at 8 o'clock on the second morning, the regurgitated fluids had become coffee-colored. An hour later, forty-three hours after the last operation, I reopened the wound, but failed to find the cause of the obstruction. The sutured intestines laid quite stiffly in place, being kept so by the numerous lines of sutures and the resulting plastic deposit, the small intestine was rather sharply flexed at the extremity, but not enough to obstruct. After as full a search as the condition of the patient warranted, it was concluded that the obstruction must be at the sutured portion. A loop of the ilium above the anastomosis was therefore drawn into the wound and another artificial anus made, but the obstruction was unrelieved, neither gas nor fecal matters passed, and the patient died forty-eight hours later, or four days after the operation.

At the post-mortem there was no evidence of recent peritonitis anywhere, the cause of all the difficulty being an old adhesion of the ilium to the abdominal wall at the left iliac fossa. Trailing the ilium up from the original artificial anus in the right iliac fossa, it ran directly across the abdomen to the point of attachment in the left iliac fossa, making a tense band; it then ran downward, and six feet were in the pelvis. I had drawn about two feet of these six under the band and used them for the anastomosis operation. The remaining four feet, still in the pelvis, were sloughing, its circulation being entirely shut off by the band. All the parts above the band, including the intestines used in the anastomosis operation, were in admirable condition. The immediate cause of the obstruction was the increased tension of the band, produced by pulling another loop of intestine under it at the operation. This band would probably have given trouble even if the anastomosis operation had not been performed.

The result in this case has not made me feel dissatisfied with the operation. I still think that it is the only tried method of obtaining a sufficiently large opening between intestines. Any smaller opening, no matter how made or with what devices, will be apt to contract and obstruct.

The Abbé operation can be quiet rapidly performed. In the case above narrated, the patient suffered from no appreciable shock, though he had but recently recovered from a nearly fatal illness.

In performing this operation again I should make the incision in the median line, and make it higher and longer, so that I might not only see the condition of the intestines, find any abnormal adhesions, but before joining the intestines I should place them in position in the abdominal cavity so that they might lie without strain or tension. The intestines, when joined by six lines of sutures, are as unyielding as if there were a piece of card-board between them five inches long. If the intestine does not lie easily in its new position, the bowel at one end or the other of the stiffened portion may be so sharply flexed upon itself as to cause obstruction. In addition, from the same cause, there may be unnecessary strain upon the sutures.

The sutures in the above case were severely tested, the transverse colon was pulled upward by the gastro-colic omentum, while the ilium, a few inches below the suture, was fast anchored by the adhesion. This strain was greatly increased by the subsequent abdominal distention and frequent vomiting. But as the specimen, which I here exhibit, shows, it held perfectly.

The specimen removed at the enterectomy shows almost complete obstruction, the opening that remains being less than a quarter of an inch in diameter.

DISCUSSION.

Dr. W. W. Keen: The question of contraction again comes up. I have a patient on whom I did a gastro-enterostomy a year ago, making an opening only an inch and a half in length. He is still perfectly comfortable. But in spite of such a result in a single case I believe that the long incision advocated by Abbé is the right one.

Mr. Treves has a brief article in a recent issue of the *Lancet*, reporting a case in which he removed a portion of the sigmoid and brought the bowel together end to end in a very simple way. He first sewed the mucous membrane of one end to that of the other all around, and then inverted the peritoneum with a simple Lembert suture. The operation was done in a comparatively short time and the patient recovered beautifully.

INDIVIDUAL EXPERIENCE IN THE TREATMENT OF VESICAL CALCULUS.[1]

By JOHN ASHHURST, Jr., M. D.

I FIND in looking over my records that I have removed calculi from the human body in fifty-one cases. One case was that of a female child, on whom I performed lithectasy, or rapid dilatation of the urethra, but the remaining fifty were in male subjects. In thirty-five of these fifty cases the patients were operated on by lateral lithotomy, which is the cutting operation that I prefer. I recognize that there are cases in which the median operation is to be preferred, and that there are other cases in which the supra-pubic operation is the best, but where the surgeon has the choice of operation, I think that he should select lateral lithotomy. Of the thirty-five cases operated on by the lateral method, twenty were in children under the age of puberty, and in every case the patient recovered. In males beyond the age of puberty, including a fair proportion of quite old persons, I have had fifteen cases with three deaths, but only one of these three was really the result of the operation. That occurred in a case operated on in a neighboring town this winter. Secondary hemorrhage occurred on the ninth or tenth day, and the attempts made by the attending physician to control it were not successful.

I have six cases of the median operation, with one death, to report. In one case the operation was done for the removal of a foreign body, the end of a catheter. In this case I succeeded not only in removing the foreign body, on which there was a small calcareous deposit, but also in relieving the chronic retention of urine, from which the patient had long suffered, by tearing off the median lobe of the prostate with the forceps. This was fully ten years ago; the patient is still living, and I believe has not had occasion to use a catheter since. The case which proved fatal was in a patient in the last stages of cystitis and chronic renal disease, and in which the presence of the stone was simply a complication. An interesting feature in this case was that, in addition to the presence of the stone, there was a large quantity of that

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semi-organized material which has been described by Vandyke Carter as the animal basis of calculi.

I have one case of the supra-pubic operation, in which the stone was a small one, this particular operation being chosen because the case was really one of villous tumor of the bladder, and the presence of the stone was simply a complication. The patient was in a critical condition from hemorrhage at time of the operation, but made a good recovery.

I have no case of the old-fashioned lithotrity. The operation had already come to be rarely practiced before I had occasion to resort to the crushing method. The early portion of my practice was largely with children, and Bigelow's modification had already become the operation of preference when I first felt I had a case adapted to its performance. I have performed this operation eight times, with six satisfactory recoveries and two deaths. Both the deaths were from uræmia, dependent upon chronic disease of the kidney.

I have brought here a number of the calculi which I have removed. The largest weighs three ounces and some drachms. It was removed by the ordinary lateral operation. It was not necessary to enlarge the wound by dividing the right side of the prostate, nor was it necessary to crush the stone. By making a large external wound, by grasping the stone with sufficiently powerful forceps, and by patience in manipulation, this stone was removed without difficulty, and the patient made an excellent convalescence.

The largest number of stones which I have removed from one patient is fifty-four. These were removed by lateral lithotomy. The patient made a good recovery, but returned in a year or so with recurrence of the symptoms from a descent of more stones from the kidney. On that occasion I determined to perform the operation of litholapaxy. The patient did pretty well for a few days, but then the urine became turbid, containing a large quantity of ropy mucus and pus, uræmia developed, and the patient died in convulsions. This was a forcible illustration of the risk attending litholapaxy in cases of cystitis, and since the occurrence of that case I make it a rule, where the patient presents cystitis in an advanced degree, to recommend the cutting rather than the crushing operation.

With regard to the results that I have reached from my own experience, I would say, in the first place, that I have never seen any reason to wish for a better operation than lateral lithotomy in children. Litholapaxy has been resorted to successfully a number of times, and with the improved instruments which we now have the operation is a feasible one, while it could hardly be considered such a few years ago. Until within a short time it has not been possible to get instruments of sufficient strength and delicacy for use in the urethræ and bladders of children. Even now, the operation of litholapaxy in children seems to me to be a more severe one than lithotomy. The results of cutting for stone in children are so satisfactory that I think we want nothing better. The great advantage of litholapaxy it seems to me is the short time required for after-treatment. If all goes well, litholapaxy will allow the patient to go about his business in five or six days. This is a great advantage in adults who are engaged in active business; but in young children it is a matter of no importance. At the same time I am willing to admit that the operation has been improved to such an extent that it is one which may be legitimately resorted to in children if the surgeon thinks that it is preferable.

The median operation seems to me to have a very limited field. Cases of foreign body in the bladder, and cases of very small stone, are those to which this operation is adapted. In some of my cases the operation was not begun with the knowledge that a stone was present, but for retention of urine where it was not possible to pass an instrument by the urethra. The argument which has been advanced in favor of this operation, that it is attended with less risk of hemorrhage, does not seem to be entirely well founded. There is very little more risk in the lateral operation. The transverse perineal artery is divided, but with a little care it is not likely that the internal pudic or the artery of the bulb will be injured. In the old days of oper-

ation without an anæsthetic, it was quite possible that one of these arteries might be wounded in the struggles of the patient. The artery of the bulb can be avoided by striking the staff as far back as possible. The hemorrhage from which I have had trouble has been from the prostatic plexus of veins, and this is quite as likely to occur in the median as in the lateral operation, and, indeed, I have seen very profuse hemorrhage from this source after median section.

The supra-pubic operation, although just at present the fashionable method, I should reserve for very large stones, or for cases in which there was some complication, such as tumor, in addition to the stone. Cases of vesical tumor are more satisfactorily dealt with through the supra-pubic incision, but where the case is an uncomplicated one of stone, I have not seen any reason to prefer this to the lateral method.

In the female, the operation of lithectasy or rapid dilitation is the one to be chosen, and in almost all cases will be sufficient. Mr. Bryant has shown that stones of considerable size can be removed by this method. In children, stones up to half an inch in diameter, and in adults stones up to one inch in diameter, can be thus removed. If the stone is larger, it can be broken into several fragments before removal. I believe that the results of this method will be more satisfactory than if an attempt is made to remove the calculus by litholapaxy or by any form of lithotomy. The vesico-vaginal section may leave a permanent fistula. The high operation may, of course, be required for very large stones.

As regards the operation of lateral lithotomy, the points which are to be observed are, in the first place, to make a large external wound. I have seen very serious trouble result from too small an external incision. There is no objection to a large wound through the skin and superficial fascia; if hemorrhage occurs, it is easier to deal with it through a large wound, and drainage is more satisfactorily effected. In the second place, I think that it is of great importance to strike the staff as far back as possible. Instead of striking it where it is most superficial, I endeavor to get as far back toward the horizontal portion of the staff as possible. In that way you avoid wounding the artery of the bulb, and obtain plenty of room where it is needed. My preference is to have the staff firmly hooked up under the pubis, instead of having it made to project in the perineum. I believe that in this way it is more firmly held, and that the surgeon can fix the position of the anatomical points better, and therefore cut with more precision. Having struck the staff, I think, following the advice of Sir William Fergusson, that the deep incision should be made small. I believe that there is a decided advantage in this plan. I do not say that the surgeon should not make the wound in some degree proportionate to the size of the calculus, and in cases where there is a large stone, I am in the habit, as I withdraw the knife, of bringing it slightly away from the staff so as to enlarge the deep wound. In children the knife should be withdrawn in close contact with the staff; but in the adult I drop the knife a little, so as to enlarge the wound in the prostate. The finger is then introduced, and the prostatic enlargement completed by dilatation. I do not at all agree with the view of Mr. Teevan, that it is safer to cut the prostate than to stretch it. In the introduction of the finger, I lay stress on its introduction above the curve of the staff. In children this is very important, for if it is not done, the finger may not enter the bladder, but may pass into the recto-vesical space. The surgeon cannot miss the bladder if he passes the finger above the staff, as it is well held up under the pubis.

In my earlier operations I had a great fancy for the scoop in removing calculi, using it as the obstetrician uses the vectis, getting the scoop behind the stone and the finger in front of it, andbringing all out together. Of late years I have used the forceps more and the scoop less, although at times it answers a useful purpose. In the withdrawal of the stone a mistake that I have often seen made is in not carrying the forceps far enough backward toward the coccyx. The portion of the wound where there is plenty of room is far back. I have seen surgeons try unsuccessfully to remove the stone through the anterior portion of the wound, when it could have been readily

removed if the forceps had been dropped toward the back.

In the high operation it is a great advantage to have the bladder and the rectum distended, though, perhaps, not absolutely necessary. There is an advantage too, in lateral lithotomy, in having a moderate quantity of fluid, say about four ounces, in the bladder before the operation, as the gush of water, when the bladder is opened, will bring the stone down on the end of the finger. If, however, the bladder is so intolerant, I do not care to have it much distended.

With regard to the operation of litholapaxy, the points which I consider to be of importance, are, in the first place, to crush the stone as thoroughly as can be done, and then, when using the evacuator, to make the stream enter with great gentleness. I believe that cystitis may be aggravated or even caused by using too much force. As regards the rapidity of the operation of litholapaxy, I have no doubt that an operator will do it with greater rapidity as he does it oftener, but for my own part, I have found it a slow operation. I think that no surgeon should undertake it who is not prepared to give as many hours to it as may be necessary. I can recall three cases in the practice of other surgeons in which the patients died as the direct result of having a stone left half crushed in the bladder. Violent cystitis came on and the patient succumbed. Where the operation is undertaken, it should be completed. If the surgeon is not prepared to remove the entire stone at one sitting, he should not undertake the operation at all. This is the operation for small stones in patients with healthy bladders. Cystitis is the most dangerous condition in which to resort to litholapaxy. In the case of an adult presenting himself with stone, my first thought is of litholapaxy. I then consider the various circumstances in the case. Litholapaxy has so many advantages in cases to which it is adapted, that I think it should be the surgeon's first choice.

With regard to the objection that lateral lithotomy may render the patient sterile, I do not see why that should be, provided that the operation is confined to one side of the perineum, and that no undue amount of inflammation follows. If there were a great deal of inflammation, it is quite possible that there might be such obstruction of the vas deferens as to prevent the patient from generating with the testis of that side, but there is no more reason why the patient should be rendered sterile by the operation of lateral lithotomy than by the removal of one testicle. In the immense number of operations performed in former years, we never heard of this objection, and I believe that it is rather theoretical that practical.

I have had one case of stone weighing less than two grains, which I diagnosed by the sound, and removed by lateral lithotomy. The patient was a lad who had the symptoms of stone in the bladder, and in addition, frequent attacks of sudden and complete retention of urine, due to the calculus entering and plugging the internal meatus. The straining was so excessive that, in the effort to pass water the night before the operation, the patient ruptured sub-conjunctival vessels in both eyes.

I wish to refer to a few cases of cystotomy for other causes than calculus. I do not include cases where I have operated by Sir Henry Thompson's method of puncturing a contracted bladder above the pubis. I find that I have opened the bladder by cystotomy in eight cases, six of these being cases of cystitis. Of these six, four recovered and two died, as the result of the diseased state of the urinary organs. In two instances I have opened the bladder for intense pain in the act of micturition, due to a fissure at the neck of the organ. Both patients recovered. In one case the fissure followed cystitis, the result of gonorrhœa, and in the other case, the symptoms came on after the use of very large sounds.

I have had one case of cystotomy in a child for tuberculous disease of the bladder. This case was of a good deal of interest. The patient had, at one time, been under the care of the late Professor S. D. Gross, who had sounded the child, and said that he felt a stone. It is to be observed, however, that he never appointed a time to operate, so that it is possible that he may have had some doubts as to the diagnosis. A curious feature of the case was that the father, who was a man of considerable intelligence, declared that he had himself dis-

tinctly heard the click of the stone against the instrument. I sounded the child, but was not entirely satisfied that a calculus was present, although, from the history, I thought it probable. The child had all the usual symptoms of stone, except sudden arrest of the urine. I asked Dr. Forbes to see the case with me, and we thought it right to open the bladder. No stone was found, but there were discharged twenty or thirty little bodies which I presume were what the older surgeons would have spoken of as fibrinous calculi. They looked like little pieces of catgut. Whether these were masses of tuberculous material, or of inspissated mucus and lymph, I do not know. The patient was relieved of his symptoms, but died two months afterward of tuberculous disease of the mesenteric glands.

DISCUSSION.

Dr. John B. Deaver: I was glad to hear Dr. Ashurst refer to advanced Bright's disease and cystitis as contra-indications for litholapaxy. I have been struck with the fact that concussion of the bladder walls during the washing out of the fragments must be an exciting factor in producing an uræmic condition when there is disease of the kidneys. I recall one case operated on by one of the older surgeons, where uræmia occurred within twenty-four hours after the operation. I have known of one or two such instances. In other cases, apparenty similar in character, lithotomy had been performed, and no trouble has followed. There is no doubt there is some connection between the operation of litholapaxy and uræmia. In the cases where I have performed the operation, I have had a careful examination of the urine made to exclude cystitis and chronic affections of the kidneys before operating, in addition to making the other tests familiar to you all.

Dr. H. R. Wharton: In regard to litholapaxy in children, my experience is limited to one case, which was that of a child six years of age. The operation was quite tedious. I think that it took at least an hour to remove not a very large stone. The child stood the operation very well, and at the end of the fourth day the urine was perfectly clear and child was out of bed.

REPORT OF A CASE OF BEZOLD'S VARIETY OF MASTOID DISEASE.[1]

By WILLIAM J. TAYLOR, M. D.,

[Surgeon to St. Agnes Hospital; Assistant Surgeon to the Orthopædic Hospital and Infirmary for Nervous Diseases.]

THE following case was admitted into the surgical ward of St. Agnes Hospital on the evening of May 1, 1892.

Henry M., aged twenty-five years, and unmarried. Family history was very good. Some seven years before, he suffered from "a running" from the right ear which lasted for only two or three days. It received no treatment, but got well of itself, and from that time until the beginning of the present illness he has had no further trouble. About Christmas-time, a little over five months before his admission into the hospital, he had an attack of something resembling "la grippe," accompanied by sore-throat of a mild type; from this illness he also recovered rapidly.

The present illness began about the 30th of March, with pain in the right ear and headache. This pain persisted, and in about two weeks it centred in the ear.

He was then treated for over two weeks as an out-patient at the Medico-Chirurgical Hospital. He became much worse and was confined to his bed.

The day before his admission into the hospital he was seen by Dr. O'Hara, who, with the aid of Dr. Brinkmann, made an incision over the mastoid region. They could find no perforation or necrosis of the bone, and on account of the gravity of the case and because he could not receive proper care and nursing at home, he was sent immediately to St. Agnes Hospital. Upon admission his condition was one of pronounced septic poisoning, and when I saw him the next morning I feared the process had extended to the lateral sinus, and possibly to the cerebral tissues. His mental condition was dull and his vitality much depressed. The temperature was 100° F., and the pulse weak and very rapid. There was paralysis of the right facial nerve, but no evidences of cerebral motor disturbance. As it was plainly to be seen that delay would be dangerous, he was placed under the in-

[1] Read before the Philadelphia County Medical Society, May 10, 1893.

fluence of ether at once. There was much swelling and œdema over the right mastoid region, which extended downward into the neck, quite to the upper border of the clavicle. The skin of the neck was much reddened and congested. Pus was seen coming from the incision which Dr. Brinkmann had made behind the ear, and from the external auditory meatus. This incision was enlarged and the bone exposed and found to be hard and white, but pus was seen coming from below and from the direction of the auditory canal. The incision was extended downward into the neck, across the tip of the mastoid process, and over the sterno-mastoid muscle. This liberated a large quantity of pus. The tip of the mastoid process was now found to be necrosed, and the whole medial surface of the process was softened and broken down. A probe, and afterward a curette and the finger, could be passed from the inner or medial side into the centre of the mastoid antrum.

The posterior wall of the auditory canal was now chiselled through and the middle-ear cavity curetted with care but great thoroughness, and a large amount of cheesy pus removed.

The pus had burrowed into the digastric fossa and then down the neck beneath the sterno-mastoid muscle and along the tract of the great vessels.

All of the mastoid process which showed evidence of necrosis was carefully removed by means of the chisel and curette, and the whole wound thoroughly disinfected. The deep wound in the neck was drained by means of large rubber tubing, and was packed with iodoform gauze. As I did not have at hand rubber tubing of proper size, I passed a bundle of horsehair down through the external auditory meatus into the middle ear and out through the wound in the mastoid process, thus insuring free exit for all pus. The remainder of the wound and auditory meatus was packed lightly with iodoform gauze.

An ample dressing of bichloride gauze was now applied, covering the whole side of the head and neck, and the patient placed in bed. I feared, as previously stated, that cerebral abscess or other extension of the septic process had already occurred, but my dissection had been so extensive and the operation so prolonged that I thought it best to wait and see if further operative measures would be necessary.

His general condition by this time was grave and the shock was most profound.

The improvement in his symptoms manifested itself almost immediately. Reaction from the effects of the operation was somewhat slow but sure. His progress toward recovery was from this time rapid and without special interest. Within a few days the drainage-tubes and horse hair were removed, and the wounds, which had not been closed by sutures, were packed gently with iodoform gauze to insure free drainage, and a generous bichloride gauze dressing was applied over the whole side of the head.

On the seventh day his temperature had reached the normal, the highest point being 100¾°, and this on the day following the operation, and remained so from that time out. For a long time, however, his heart was extremely weak. No valvular lesion could be detected, but the pulse was very weak and very rapid. There was also a difference in volume between the two radial pulse-beats.

Under the free administration of tonics, stimulants, and good food, he rapidly improved in health and strength, and was discharged from the hospital, July 14th, well.

The facial paralysis persisted, however. This gradually improved, but up to the date of his discharge from the hospital his inability to close the upper eyelid was very apparent. The uvula was paralyzed on the right side, and the sense of taste diminished on the right side of the tongue as well.

His general health was very fair, though he still showed in his appearance signs of the severe illness through which he had passed.

On October 5th he was examined by Dr. Isaac Barton, who sent me the following report:

"I find evidence of a ruptured membrane, possibly for the escape of pus from his right side. The membrane now has partially re-formed, and his hearing with the watch on the right side is four

inches, on the left side normal. The 'A' tuning-fork is heard at five inches on the right side, while on the left it is normal.

"Bone conduction on the right side is very poor with the 'A' and 'C' tuning-fork, being the result of the operation and previous condition of the mastoid cells (of the right side). Nasal passage, anterior and posterior, somewhat congested but free for breathing space. Eustachian orifice of left side normal, that of the right side much thickened but not occluded."

In December, Dr. O'Hara called me to see him in consultation, as symptoms of typhoid fever were present. By this time the facial paralysis was entirely relieved, but he passed through a typical attack of typhoid fever. He had several hemorrhages from the bowels, and in the course of a few weeks periostitis of both shin bones developed. Suppuration occurred Dr. David Bevan very kindly made a bacteriological examination of some of the pus and reports staphylococcus pyogenes albus.

A CASE OF DIPHTHERITIC CROUP IN WHICH A TRACHEOTOMY-TUBE WAS WORN FOR SIXTY DAYS.[1]

By H. R. WHARTON, M. D.

ON December 20, 1892, I saw a child eighteen months of age, who was suffering from diphtheria, who exhibited marked symptoms of dyspnœa. I introduced an intubation tube which relieved the dyspnœa, but at the end of fifteen hours this was coughed up, and I was summoned to see the case again, and found that the dyspnœa had returned. I then performed tracheotomy, and after the operation the dyspnœa was entirely relieved, and the patient subsequently did well.

On the tenth day after the operation the tracheotomy-tube was removed and the patient breathed comfortably, but in fifteen or twenty minutes after the removal of the tube the dyspnœa rapidly recurred and became so urgent that I had to replace the tracheotomy-tube.

Attempts were again made to remove the tube at intervals of a day or two for a week or more with a similar result. Four weeks after the operation the child was etherized and the tracheotomy wound was dilated, so as to expose the wound in the trachea. It was then found that there were a number of masses of granulation tissue springing from the trachea in the region of the tracheal incision; these were removed with forceps and scissors, and the tracheotomy-tube was again introduced. After waiting a few days another attempt was made to remove the tracheotomy-tube, but this also failed. An intubation-tube was introduced upon the removal of the tracheotomy-tube, and was worn for some hours, and upon its removal the child was able to breath comfortably for five hours; but after this time dyspnœa recurred, and the tracheotomy-tube was again introduced. After several trials of the intubation tube, it was finally abandoned, and it was decided again to etherize the patient and examine the tracheal wound, fearing the granulations had recurred. The patient was etherized and the tracheotomy wound was enlarged so as to expose the tracheal wound, and it was found that a number of masses of granulation tissue were present; these were removed with forceps and scissors, and their bases were touched with the solid stick of nitrate of silver. An intubation-tube was then introduced, and it was worn for twelve hours, when it was coughed up. Thinking its expulsion was probably due to the irritable condition of the larynx and trachea, resulting from the recent operation, I waited forty-eight hours and then replaced the intubation-tube. To keep the tracheotomy wound open, so that the tracheotomy-tube could be introduced, if it were required, I introduced an obturator into the tracheotomy wound. The intubation-tube was worn for four days and was then removed, and the obturator was retained in the tracheotomy wound for three days longer, and was then removed. The child after this time had no further difficulty with his breathing, and the tracheotomy wound, after the removal of the obturator, rapidly contracted and healed. The patient wore the tracheotomy-tube for a period of sixty days.

[1]Read before the Philadelphia Academy of Surgery.

A case of intubation of the larynx, in which the tube was worn for fifteen days.—On February 24, 1893, I saw, with Dr. H M. Fisher, an Italian child less than two years of age, who was suffering from marked dyspnœa, which had come on gradually in the previous forty-eight hours. I introduced an intubation-tube in this case, which completely relieved the dyspnœa, but is was coughed up in twenty-four hours, and the next larger tube was introduced. On the third day, the tube was removed and the child breathed comfortably for half an hour, but after this time the dyspnœa gradually returned and the tube had to be reinserted. Another attempt was made on the sixth day, and the tube was kept out for three hours, and after this time the dyspnœa recurred and I was compelled to reintroduce the tube. Attempts to remove the tube were made at intervals of two days, with a like result, and it was only on the fifteenth day that the tube was permanently removed.

In this case I noticed in each removal of the tube that there was little expectoration of mucus or membrane and that the cough was croupy and it was observed that at the time of the final removal of the tube that the cough was loose.

In all acute cases the patient is usually able to dispense with the intubation-tube in from five to eight days; this case wore the tube for fifteen days, the longest period in my experience that an intubation-tube has been required.

Two cases of excision of the hip-joint for Coxalgia.—I. Harry O'Neill, aged seven years, was admitted to the Children's Hospital April 27, 1892, having suffered from coxalgia for two years, and been under treatment in three different hospitals before he was sent to the Children's Hospital. When he came under my care there was a sinus on the outer aspect of the thigh, which discharged profusely, and he had the scar of an incision which had been made for drainage, upon the anterior surface of the thigh over the hip-joint.

On July 5, 1893, as the patient had suffered some time with a high temperature, and as he was rapidly losing ground, I decided to excise the hip-joint, and upon exposing the joint I found the head of the femur separated and represented by a small irregular sequestrum, and the neck of the femur had undergone marked absorption, the acetabulum was roughened, but not perforated. The patient did well after the operation; the wound healed promptly and he was sent to the country branch in two or three weeks after the operation.

I show the patient, ten months after the excision of hip-joint, and you see he has a very firmly healed wound and a very good range of motion at the false joint; his general condition is also excellent.

II.—Charles G., aged eleven years, suffered from coxalgia when eight years of age; was treated at the Children's Hospital as an out-and-in-patient for several years, and finally his condition became so bad by reason of the free discharge from sinus in connection with the hip-joint, and from his continued high temperature, that excision of the hip-joint was decided upon. The joint was excised in June, 1891, and the patient had a slow convalescence, but finally the wound healed, and the patient's general condition improved.

I show him to-night, nearly two years after the operation, and you see that he has a remarkably free range of motion at the false joint, and his general condition is excellent.

Specimen of fracture of the right femur showing the condition of the bone eighteen days after the injury, from an infant eight months old.—Emily S., eight months old, was admitted to the Children's Hospital, June 18, 1892, having sustained an injury of the right femur from a fall ten days before admission. Examination showed that there was a fracture of the shaft of the right femur. The child was suffering from enterocolitis at the time of admission, and was quite sick; the fracture was dressed with a moulded binder's board splint. The patient grew gradually worse, and six days after admission developed a temperature of 107° and died. Examinations of the specimen shows marked overlapping of the fragments at the seat of fracture, the shortening being at least one inch.

This specimen is of interest, as it shows that contrary to the generally accepted teaching that there is little shortening in fractures of the femur in infants, that marked overlapping of the fragments may occur, giving rise to very considerable shortening.

The Times and Register.

A Weekly Journal of Medicine and Surgery.

WILLIAM F. WAUGH, A. M., M. D.,
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THE PENNSYLVANIA QUARANTINE LAW.

THE Bliss quarantine law has received the approval of the Governor. As finally passed, it embraces the following features:

First. In view of the prospective establishment at an early date of a thoroughly equipped and effective Federal marine quarantine on the Delaware bay or river, the Governor of the State of Pennsylvania is empowered, when satisfied that the United States has established and is maintaining on the Delaware bay, etc., an effective and sufficient quarantine to secure this Commonwealth against the introduction of pestilential, contagious and infectious diseases, the Governor is empowered to suspend by public proclamation the operation of State quarantine in part or in whole, at his discretion.

Second. The Governor is empowered under certain circumstances to lease the Lazaretto Station, which station, however, must be discontinued for quarantine purposes after July 1st, 1895.

Third. The Governor is authorized to acquire, by purchase, etc., a suitable place on the Delaware river or bay either within or without the limits of Pennsylvania, for the establishment of a permanent quarantine station.

Fourth. The State Quarantine Board is to be constituted as follows:

1. The Secretary of the State Board of Health.

2. The President of the Philadelphia Marltime Exchange, or a member of said Exchange to be designated by him.

3. The President of the College of Physicians of Philadelphia, or a member of said college to be designated by the President.

4. The Quarantine Physician provided for in this act.

5. The Health Officer appointed in pursuance of the act to which this is a supplement.

6. The sixth member to be appointed by the Governor of Pennsylvania.

7. The seventh member to be appointed by the Mayor of Philadelphia.

The members of said Board serving for various terms, so that all shall not go out at one time.

Fifth. The State Quarantine Board thus constituted shall make rules and regulations not inconsistent with the laws of the United States and this Commonwealth for the regulation and management of the Quarantine Station, etc.

Sixth. The Quarantine Board shall establish an office in the city of Philadelphia.

Seventh. The Quarantine Physician shall be the Executive Officer of the Quarantine Station.

Eighth. The time the act is to go into effect is July 1st, 1893, from and after which date the offices of the Lazaretto Physician and Quarantine Master shall cease to exist.

Ninth. Section 13 provides that the power of the Philadelphia Board of Health over maritime quarantine ceases when this act goes into effect.

An appropriation of thirty-five thousand dollars ($35,000) towards the cost of securing a site and equipping same, in conformity with the requirements of this act, was passed during the last days of the legislative session.

The value of the measure will depend altogether on the personnel of the Board. Dr. Lee has done such good work as a sanitarian that his efficiency may be safely assumed. The participation of

the Maritime Exchange is a wise measure, as providing that the important commercial interests of the port will not be sacrificed without reason. The College of Physicians comes in next, in pursuance of a suggestion made years ago by this journal, that that learned body should get down from its scientific stilts and interest itself a little in the needs of its fellow-citizens, following the example of the French Academy. The city is amply represented, in its very efficient Quarantine Physician and Health Officer, and in one member to be appointed by the Mayor. Whoever his choice may fall upon, he cannot do very serious mischief in a Board thus constituted. With men of practical training in sanitary science in the majority, the Quarantine Board should become an efficient coadjutor to the City Board of Health, and the public may rest assured that their interests will be secured. Not the least of the benefits of this Act is that it legislates the Lazaretto physician out of office. Altogether the Legislature is to be congratulated on a wisely executed piece of legislation.

Bureau of Information.

Questions on all subjects relating to medicine will be received, assigned to the members of our staff best capable of advising in each case, and answered by mail.

When desired, the letters will be printed in the next issue of the Journal, and advice from our readers requested. The privileges of this Bureau are necessarily limited to our subscribers. Address all queries to

Bureau of Information,
TIMES AND REGISTER,
1725 ARCH STREET, - Philadelphia, Pa.

STRYCHNINE FOR THE AGED.

PROF. WAUGH cautions us against giving strychnine to old people with hypertrophy of the heart. I would like to ask the Professor why? I do not remember seeing it interdicted; and in conversation with some old physicians, they could not see why it should not be used. Let the Professor give us a short article on it. D. F. HUDSON, M. D.

RUSSELL, KY.

[Strychnine is not indicated in hypertrophy of the heart, and is capable of doing great mischief, by increasing the force of the heart in pumping blood into vessels which, in such cases, are very likely to be atheromatous, and thus causing apoplexy.—W. F. W.]

POLYURIA.

ALLOW me to call on your valuable paper for a little help. It would be impossible for me to get along without the TIMES AND REGISTER. Mr. B., aged 60 years, general health good, has been passing a large quantity of urine for the past six months; but there is no albumen or sugar in the same. It has a a specific gravity of 1012. He has no pain in his back, and is not thirsty. I am not able to discover anything wrong in his system to account for the trouble. Please give me your view of the case from this brief description; also the treatment. J. D. BENNETT.

PIKES PEAK, MICH.

[If there is no sugar, it is diabetes insipidus, or polyuria. The remedies are: a full dose of pilocarpine, followed by ergot, unless the pulse shows undue tension; when nitro-glycerine is the remedy. Limit the quantity of liquids taken, and keep the skin active by baths, followed by rubbing with coarse towels.—W. F. W.]

GREEN DIARRHEA.

I HAVE a patient, a babe nine weeks old, who has been suffering for a period of four weeks with green stools, but no diarrhœa. Also there has been a great deal of cough. I notice that when the stools assume a semi-yellow color, the child is much brighter. This morning in making my call, I found an entirely green stool and the child restless and feverish. There is some vomiting, with an anemic condition of the mouth.

There is a disposition on the part of the child to throw its head back, as in brain trouble, whenever the stools are green.

There is considerable gas formation in the bowels. I am giving bromides to secure rest and bicarbonate of soda with pepsin for the stomach. The child never

suffers from fever unless its stools are quite green

I should be glad to have you advise me what to do to correct the stools. Unless I can accomplish this I fear I will lose the little patient. He nurses the mother's breast strongly every two or three hours. To what is the green stool due? The milk is well digested in the stools, and there is no fetor about them.

C. W. HUGHES, M. D.

BIG RUN, PA.

[The green stools are generally thought to be due to the decomposition of bile; though Hayem asserted that a specific microbe was concerned in their production. He advised the use of lactic acid, ♏ j, every two to four hours. I have obtained the best results from the use of zinc sulphocarbolate, gr. ½, bismuth subnitrate, gr. j, and saccharated pepsin, gr. j, every hour or two.

—W. F. W.]

AURAL SYPHILIS.

THE case reported in Vol. XXVI, No. 21, of the TIMES AND REGISTER, for which an anonymous colleague asks an advice, concerns a patient with a buzzing noise in the left ear, lasting four years, itching of the meatus, and the feeling of shaking water in the ear, together with the history of syphilis of his wife and baby. Although the probability of syphilis is emphasized in the answer, if a foreign body can be excluded, I would agree with the diagnosis, if the following questions could be answered:

1. What is the condition of the membrana tympani, when examined by the otoscope?

2. What is the result of the examination of hearing for the watch and voice?

3. What is the result of examination with tuning forks?

4. Is the tinnitus continuous, day and night, and very distressing in character, or is it intermittent?

5. Is there any complaint of vertigo?

Since aural patients suffering from syphilitic disease are attacked *with predilection* in the labyrinth, and the symptoms mentioned in your case do not point to that organ, it would seem somewhat rash to make the diagnosis of aural syphilis without answering the questions as given above.

MAX TOEPLITZ, M. D.

Assistant Surgeon to the N. Y. Ophthalmic and Aural Institute.

MORPHINISM.—STRYCHNINE.

SOMETIME ago I wrote to you about a couple of patients I had who were in the habit of taking morphine. Well, I have got rid of them; I candidly told them they would have to go to some retreat, as I was powerless to do any thing for them. I am glad for my peace of mind that I have no more such cases, nor do I want them. They are a little out of my line. I certainly sympathize with any physician who has to treat these cases, he must have a World's Fair of patience, forbearance, etc., too numerous for one mortal to mention.

I saw a remark of yours some time ago that strychnine was a great tonic. I want to know how far, generally speaking, one dare go with this remedy. Would you combine it with phosphoric acid and add syrup, instead of giving it in drop doses (that is, when you give it for the patient to take himself)? I feel confident from your experience you can aid me. I have some patients who want to have something to make them feel better, and I have thought that strychnine would be indicated.

[You have reached the conclusion to which the physician is sure to come, who tries to treat morphinism at the patient's home.

As to strychnine, in ordinary cases the fortieth of a grain, three times daily, is a good average dose. Aged people bear much larger doses; and, in fact, it may be increased to gr. $\frac{1}{20}$ or even $\frac{1}{10}$, if the tension of the pulse be noted But this tension would be dangerous in hypertrophy of the heart, or in atheromatous disease of the arteries, and caution should be exercised in such cases. This is the more needful, as strychnine in heroic doses has been highly recommended as a tonic for aged persons, without noting these exceptions.—W. F. W.]

VARICOCELE. — ANGINA PECTORIS.

I DESIRE the best treatment for varicocele. I have ligated the veins in several cases by passing a ligature around them and tying it tightly, but afterwards there would be left one or two veins, principally in the bottom of the scrotum, that would enlarge when the patient stood on his feet.

I would also like to know if there is any new remedy that has any effect on angina pectoris. I have a case, caused by fatty heart with degeneration of the blood vessels of the head. I have used all the remedies advised in text books,

without giving any but very temporary relief. An answer by a member of your staff would be gratefully received.

R. A. REGER, M. D.

BUCKHANNON, W. VA.

[If ligation fails, the enlarged veins can be excised. But as some veins must still be left to return the blood, these will enlarge, unless the causes of varicocele are remedied. Treat the constipation, order cold douches, and a suspensory bandage. See Dr. Lydston's excellent little book on varicocele.

The directions for the treatment of feeble heart have been given in another letter in this issue. For angina pectoris, the pain may be most promptly relieved by nitrite of amyl, or nitroglycerine. Apply a quickly-acting rubefacient over the right pneumogastric nerve in the neck. For the arterial disease, give iodoform, gr. j, thrice daily.—W. F. W.]

HEART DISEASE.

I HAVE a patient with disease of the heart and lungs; spitting blood, though not much at a time; has some pain around the heart. He is able to do but little work. The pulse stands at about one hundred. He eats well, but the pain causes vomiting, and when this comes on he has to stop work. I do not find much the matter with the heart, except that it is quite weak, so that at times it is hardly perceptible at the wrist, although regular in rhythm. The respirations are normal. He is unable to run or to walk fast, as this excites the heart very much. There is not much digestive trouble. He has had many advisers, but obtained very little benefit.

A long life to you and to the TIMES AND REGISTER.

Z. R. MILLARD, M. D.

THACKERY, ILL.

[The symptoms point to heart disease, with failure of circulation, from valvular disease, followed by dilatation and fatty degeneration. The end is death, preceded by dropsy. Give tincture of digitalis, gtt. xx, every four hours for a week; then follow with spartein sulphate, gr. ½, quinine sulphate, gr. ij, and iron sulphate, gr. j, in pill four times daily. Put the patient on a rich, highly nutritious, but dry diet, using as little liquid as possible. Increase the heart's strength and diminish its work by enriching the blood and reducing its watery elements.—W. F. W.]

ECZEMA.

I HAVE a young friend, clerk in a drug store, who has for two years suffered from eczema of the face and scrotum. He has taken Fowler's solution for eighteen months, and nearly everything else, but gets no better, except that the discharge has ceased. Could you suggest a remedy? He seems to be quite healthy, is stout, and a hearty eater, but is careful as to his diet.

Since your sulphocarbolate of zinc has come in vogue, typhoid fever is as easily treated successfully as a bad cold.

W. S. CLINE, M. D.

WOODSTOCK, VA.

[Keep the bowels and urinary apparatus in order; forbid malt liquors, tomatoes, coffee and condiments. Apply to the eczematous surfaces an ointment of biniodide of mercury, ten to twenty grs. to the ounce for the face, but weaker to the scrotum. Internally give lobelia in doses just less than what will produce nausea.—W. F. W.]

ARSENITE OF COPPER.

IT is just about the time that the "arsenite of copper" is in order, and I would like to know, in your next issue, *how* and *when* to use the same for adults as well as children.

Of course, I know something about it, but would like to hear from some one who has tested it thoroughly.

My first inquiry to your paper was answered so promptly and satisfactorily, that I appreciate your Bureau of Information; hence my second request for help.

R. R. C.

[Dr. Aulde is the authority on arsenite of copper. I have not obtained any benefit from it in summer complaint, or in cholera infantum. In the irritative diarrhea of adults, when the taking of food excites the bowels to action, it has proved useful, in doses of gr. $\frac{1}{15}$ every two to four hours. Also, when diarrhea or dysentery tend to become chronic, it has been of benefit in the same doses. Excepting in these cases, I have not found the arsenite of copper as useful as other remedies. It must be borne in mind that for the same class of affections for which Aulde recommends this drug, I introduced the sulphocarbolates, and my verdict may be influenced by the natural partiality of a father for his own children, or by the fact that I have acquired the skill that comes from much experience in the use of my favorite drug. Still, I try to be as impartial as possible, and the above is my sincere belief.—W. F. W.]

FACIAL NEURALGIA.

I HAVE a delicate female patient who suffers with facial neuralgia. Can you tell me the best remedy?

[Try the modified anti-nervine formula, equal parts of acetanilide, soda salicylate and ammonia bromide, five grains of each, every two hours. Many of these cases are beyond drugs, and require surgical aid.—W. F. W.]

EXPERT TESTIMONY.

I AM called upon to give expert testimony in the following case: Miss C. testifies that while she was engaged as a domestic at the house of Mr. H., (a widower), she was seduced, and became enceinte by him.

Mr. H. says it is a scheme to draw money from him, declaring that he "never touched her;" and that he can prove by his physician, etc., that he was suffering from gonorrhea during all the time that she was at his house. Now the question is, could she become pregnant from intercourse with him, he having the clap, and not take the disease? I would be thankful for advice upon this. H.

[As we understand the case, the woman claimed to be a virgin, inexperienced in such matters. For such a one, escape from contracting gonorrhea would be practically impossible under the circumstances (she being destitute of the immunity possessed by old hands), unless she employed preventatives. These would equally prevent pregnancy. She could not become pregnant from him without becoming also affected with gonorrhea; and the gonococcus is so inimical to the spermatozoon that it is exceedingly unlikely that she could become pregnant at all under these circumstances without at the same time contracting gonorrhea. So true is this, that in seeking for the causes of sterility, we always look for the possibility of gonorrhea being present. But Mr. H. has placed himself in a very dubious position by his defence; for he has acknowledged that no principle restrained him, since he had contracted gonorrhea, presumably by immoral sexual congress; while if Miss C. claims to have also contracted gonorrhea, and can prove it, he is dished.—W. F. W.]

"CONTINUED REMITTENT FEVER."

I WRITE to ask concerning a febrile affection prevalent here, which, for want of a better name, I have called the "continued remittent." Is there any treatment that will cut it short? Quinine fails, as does everything else, ordinarily.

In pelvic or general peritonitis, what is the best local application, heat or cold?

Which is best for meningitis? Can you refer me to any literature on the use of cold and heat in the treatment of disease?

M. M. GILBERT, M. D.

MESA, ARIZONA.

[1. Try sulphocarbolate of zinc, gr. ij, every two hours, with bismuth subnitrate, gr. v. 2. I would use whichever is most agreeable to the patient. 3. Cold, by all means. 4. Write to Dr. S. Baruch, New York City, for his work on the uses of water. —W. F. W.]

Book Notes.

APPENDICITIS AND PERITYPHLITIS. By Charles Talamon, M.D. sq. 12mo. pp 210. Geo. S. Davis, Detroit, Mich., 1893.

The author gives a very complete description of this malady, in a style which must make it valuable to the general practitioner; and his directions for medical treatment of cases suitable for this method of management are succinct and admirable. The surgical means indicated are such as have been so much talked about within the past three months by those who aim toward specialism in this line.

THE SURGERY AND SURGICAL ANATOMY OF THE EAR. By Albert H. Tuttle, M.D., sq. 12mo, pp 109. Geo. S. Davis, Detroit, Mich., 1892.

This treatise is extremely well written, and will be a good guide to all who own it, in the very troublesome disorders treated in the little work. Ear diseases are the bane of all who unfortunately have to care for them, the specialist apparently being no more successful with them than the common doctor. A number of new hints of value are given in the book, and the physician cannot err in having a copy of it in his library. The illustrations are fine.

SEXUAL WEAKNESS AND IMPOTENCE. By Edward Martin, M.D., sq. 12mo, pp 102. Geo. S. Davis, Detroit, Mich., 1893.

The volume is simply a re-written one, embodying about the same ideas as its predecessors; and we cannot agree with the author in much of his treatment. Ninety per cent of all cases of sexual weakness are the result of excesses in young and old; and stimulating remedies such as damiana, phosphorus, strychnia *et al* do naught but whip the worn out steed. Rest, bromides, camphor, with now and then in selected cases electricity, are the main agents for cure where such is possible, but the truth is that most subjects simply drift from doctor to doctor without any real gain in the end.

HANDBUCH DER OHRENHEILKUNDE. Prof. Dr. Hermann Schwartze. Zweiter Band. Mit 177 Abbildungen in Text. Leipzig. Verlag von F. C. W. Vogel, 1893. Preis 30 Mk.

This fine work ought to be translated into English, and would be, were the affections of the ear receiving their due share of attention.

THE RELIGION OF SCIENCE LIBRARY.—In order to place our publications within reach of persons of limited means and to obtain thereby a wider circulation for the same, it is proposed to issue, commencing in June, the following list of works in paper covers under the general heading, "The Religion of Science Library." The books will be issued bimonthly as second class matter, and will be printed from large type on good paper, and well bound.

The subscription price will be $1.50 a year, postpaid in the United States, Canada and Mexico; 75 cents for six months, and 25 cents for single numbers.

Special Offer. Orders sent in before June 15th, 1893, for one year's subscription will be executed at the reduced price of one dollar.

The "library" will contain among others:

The Principles of the Religion of Science. By Paul Carus, Ph. D.

Three Introductory Lectures on the Science of Thought: By Prof. F. Max Müller.

Three Lectures on the Science of Language. By Prof. F. Max Müller.

The Psychology of Attention. By Th. Ribot.

The Psychic Life of Micro-Organisms. By Alfred Binet.

Fundamental Problems. By Paul Carus, Ph. D.

On Double Consciousness. By Alfred Binet.

The Soul of Man. By Paul Carus, Ph. D.

The Diseases of Personality. By Th. Ribot.

The Ethical Problem. By Paul Carus, Ph. D.

Epitomes of Three Sciences. Prof. H. Oldenberg, Prof. Joseph Jastrow, and Prof. C. M. Cornill.

Homilies of Science. By Paul Carus, Ph. D.

The Open Court Publishing Co., 770 "The Monon," 324 Deaborn St., Chicago.

TRANSACTIONS OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION. Vol. V. 1893.

The volume contains thirty-eight papers, and the discussions thereon, by the members of this Society, among whom are to be found some of the brightest men in the profession.

The Medical Digest.

SPRAINED ANKLE.—Almost every one has had more or less experience in the twist of the ankle which strains the tendons and sometimes lacerate the capsular ligament. These sprains are often more tedious than an actual fracture, and under the old treatment required a longer time to remedy. Some years ago Mr. Edward Cotterell, of the University College Hospital, London, published a little work giving the outline of a new method of treatment which he had found highly successful. Recently Dr. V. P. Gibney, of the New York Polyclinic, has put the method in practice in his hospital and private practice with such marked success that his experience, published in the journal of that institution, has been adopted by many others. The foot, the ankle and the lower third of the leg are strapped with an adhesive rubber plaster, the foot being well raised, about half an inch in width. The first strap was carried over the outer side of the foot from near the base of the little toe, each successive strip overlapping the other until the lower third of the limb was included. Over all was placed a cheese cloth bandage. The patient was then told to put on stockings and shoes and walk, and was directed to walk every day. The recovery in each case was without relapse, speedy and complete.—*N. Y. Med. Times.*

EUROPHEN IN VENEREAL LESIONS.—In a late report in the *Therapeutische Monatshefte*, Dr. Carl Kopp, of Munich, gives the results of treatment by europhen in thirty-five cases of chancroid, inguinal bubo and the moist papules commonly observed in the genito-crural and anal regions of syphilitic subjects. In the treatment of chancroid, the ulcers and surrounding parts were first thoroughly cleansed with a 1 to 1000 corrosive sublimate solution, and the parts dried with cotton. Europhen in powder was then applied two or three times daily, the lesions being cleansed each time with the sublimate solution. In some cases the europhen powder was mixed with borac acid in various proportions ranging from equal parts of each

substance to one part of europhen and and five parts of boric acid. No symptoms of irritation were observed even where the pure europhen was employed. The time of healing corresponded to that required by iodoform under like conditions. In a few of the cases curetting was resorted to, the sores being then dressed with dry europhen after a careful application of bichloride gauze until a cessation of the hemorrage. After the formation of the crusts, europhen and boric acid in equal parts was dusted over the wounds. In cases of sympathetic inflammation of the inguinal glands with supperation, the abscesses were opened, scraped, and the parts disinfected with the sublimate solution and the cavities packed with tampons rolled in europhen-boric acid in powder of the strength of one to the former to five of the latter. The secretion remained odorless, the surrounding parts showed no sign of irritation, and fistulate was not determined in a single case. In the treatment of moist papules the object was to convert the hypertrophied and profusely secreting condylomata into the dry form and to cause cicatrization by dusting on europhen-boric powder 1 to 5. The adjacent surfaces were kept apart by the use of cotton.

DOSIMETRY.—I desire to make mention of a few remedies which I have found to be very useful in certain disorders: In cholera morbus and cholera infantum, and in all diarrhœal disturbances produced by fermentation, sulpho-carbolate of zinc is the remedy above all others of its class. When pain accompanies the above named diseases, codeine or hyoscyamine will relieve the colic. Sulpho-carbolate of zinc and codeine in ½ grain doses, given every half hour, will soon give relief, or hyoscyamine 1-250 of a grain, every half hour, will be equally effective and without bad after effects. Uterine colic from suppression of menses yielded after the second dose of hyoscyamine 1-250 and macrotin 1-6 grain, given a half hour apart. Lumbago yielded rapidly to veratrine 1-134 grain, colchicine 1-134 and macrotin 1-6 grain, given together every hour. Several cases of pertussis improved rapidly under calcium sulphide and monobromide of camphor, 1-6 of a grain each, given every two hours. Acute cystitis improved rapidly under hyoscyamine 1-250 grain, aconitine 1-134 grain and lithum benzoate ⅓ grain, given every hour. Hyoscyamine has largely replaced the opiates in my practice. In all cases of spasmodic action of the hollow viscera, hyoscyamine and strychnine will produce relief very rapidly, without any evil after effects, and, usually, before the pupil is dilated.—Schaller, *Lancet-Clinic.*

SOOTHING SYRUP WITHOUT OPIUM.—

℞ Oil anise . . . . . ♏xxv
Alcohol . . . . . ʒij
Fl. ext. valerian . . . . . ʒi
Oil peppermint . . . . . ♏xv
Tinc. camphor . . . . . ʒij
Fl. ext. liquorice . . . . . ʒi

M. Sig. Shake the bottle. Dose—One-fourth or one-half teaspoonful in water; repeat as needed.
—*Lancet-Clinic.*

THE JUSTIFIABLE PREVENTION OF CONCEPTION.—The physician not infrequently has to warn against conception in cases where a pregnancy would endanger the life or the health of the patient. Pelvic contraction, abdominal and uterine tumors, etc., form such an indication. The advice to abstain from coitus is but seldom followed, and the means usually employed to prevent gestation (mechanical) are objectionable from a hygienic and ethical point of view. Kleinwächter has endeavored to find a remedy which would have none of the aforementioned drawbacks. He prescribes a cacao-butter suppository containing 10 per cent. of boracic acid to be introduced high up into the vagina. These suppositories dissolve in about one hour, and the liberated acid destroys the spermatozoa. Bichloride of mercury in 0.001-gramme doses can also be used, but in that case a vaginal douche has to follow the sexual act. The solvency of the suppository is heightened by adding one grain of oleum olivæ. The author considers this a safe and sure remedy to prevent conception. Therapeutic effects may be combined by the adding of various drugs—for instance, tannin in cases of uterine catarrh.—*Med. Age.*

PRENTISS (*Atlanta M. and S. Jour.*) gave pilocarpine, for ten days, in full doses to a woman affected with pyelonephritis and anuria. Full physiological effects were produced, and recovery followed. Her hair, fine and yellow naturally, became coarse and dark brown during the treatment. In another case, the hair darkened, but faded a few days later. In a man 72 years old, with contracted kidneys, the eye brows and hair grew darker.

A YOUNG woman requested an examination to ascertain if she were affected with gonorrhea. There was no vaginal discharge, and no other symptom indicating such affection. However, the test paper placed in contact with the vaginal wall gave an acid reaction, and the diagnosis was guarded. Two days later a vaginitis, inexplicable save on the blenorrhagic theory, manifested itself.

News and Miscellany.

The Pennsylvania State College, at Bellefonte, holds its commencement exercises June 11 to 14.

Dr. Goodell has resigned the chair of gynecology, at the University of Pennsylvania, and Dr. Charles B. Penrose has been elected as his successor.

The Sanitarium for Sick Children, at Red Bank, was opened for the season, June 1. A large number of the friends of this most deserving charity were present.

Dr. L. Riesmeyer is the new editor of the *Weekly Medical Review*, of St. Louis. He has restored the department of Original Articles, but otherwise conducts the journal on the lines laid down by Ohmann-Dumesnil.

Klein says that tuberculin produces no reaction in tubercular cases unless the streptococcus pyogenes or the diplococcus pneumoniæ be present. Tuberculin is no specific, but rather a stimulant of pus cell potential energy, even when no tuberculosis is present.

The 127th annual meeting of the Medical Society of New Jersey will be held at the West End Hotel, Asbury Park, June 27 and 28. Papers are announced by Drs. J. W. Stickler, G. T. Welch, W. B. Johnson, H. L. Coit, J. P. Wade, W. Elmer, Jr., S. E. Armstrong, and others.

A member of our staff writes to us that in the issue of June 3, there appeared an item attributing to a distinguished French clinician certain statements in regard to bromidia. This, he says, is erroneous, no such paragraph occurring in the journal quoted. The item was copied from some source, which we cannot now recover, and inserted without the usual verification. We would be sorry indeed to injure Dujardin-Beaumetz, whose writings appear in this journal more frequently than those of any other French writer, by misquoting him; and we are sure that the manufacturers of bromidia, whom we have always found to be upright and honorable in their dealings, would regret as deeply as we the occurrence of such a mistake.

The sixth annual convention of the National Railway Surgeons' Association was held at Omaha, May 31 to June 3. Addresses were delivered by the President, C. W. P. Brock, of Virginia; E. R. Lewis, John Van Dyne, Paul F. Eve, Thomas H. Manley, D. S. Fairchild, J. A. White, and C. M. Woodward. Dr. J. B. Murphy demonstrated on a dog the use of his button for intestinal anastomosis. Many of the members, with their families, availed themselves of the courtesy of the Union Pacific Railroad, and took a run out to Denver. Galveston, Texas, was selected as the next meeting place, and the following list of officers elected for the ensuing year:

President, Dr. W. J. Galbraith; First-Vice-President, Dr. E. R. Lewis; Second Vice-President, Dr. Thomas H. Manley; Third Vice-President, Dr. E. F. Yansey; Fourth Vice-President, Dr. D. F. Stewart; Fifth Vice-President, Dr. E. A. McGannon; Sixth Vice-President, Dr. E. G. Cochran; Seventh Vice-President; Dr. W. R. Blakesley; Secretary, Dr. J.

M. Dinnen; Assistant Secretary, Dr. J. H. Ford; Treasurer, Dr. J. Harvey Reed.

Members of the Executive Committee, A. J. Mullen, Jr., to fill unexpired term of Dr. Dinnen; Dr. J. B Murphy, A. A. Thompson, C. K. Cole.

Chairman of Transportation Committee. Dr. W. B. Outten; Chairman Committee of Arrangements, Dr. C. H. Wilkinson.

Many friends of the TIMES AND REGISTER were present, besides those named; including Drs. Ritchey, of Oil City; Wilson, of St. Mary's; Starkey, of Chicago; Kibler, of Corry. etc. The Association numbers over 1500 members, of whom Pennsylvania furnishes the largest number of any one State. The proceedings are to be published in the *Railway Age.*

N. Y. STATE HEALTH BOARD REPORT.—The increase in the mortality, which began in March, and was then estimated at 2,000 above the normal for the month, has continued, with a slightly greater increase in April. The average daily mortality is 395, which is about sixty more than in January and February and eight more than in March; it is forty-two more than in April, 1892. The relative proportion of deaths from zymotic diseases is unusually low; the deaths from other causes (local diseases), while corresponding very closely with the mortality of March, being greatly in excess of that of the same period of last year. The increase of mortality for the month is not less than 2,000 above the normal and is to be traced to a continuance of the epidemic of grippe, which was estimated to have caused a mortality slightly less than this last month. The increased mortality has, as in March, been much the greatest in the Maritime District, where the death rate from diseases of the respiratory organs and of the nervous system has been unusually large. Of ordinary zymotic diseases, all show an actual as well as relative decrease, except *cerebro spinal fever*, the increased number of deaths from which occurred chiefly in the Maritime District. Of the twenty-three deaths from *small pox*, one occurred in Callicoon, Sullivan county; an outbreak is prevalent at College Point and cases have occurred at Jamaica and in the town of Southold. *Consumption* participates in the larger mortality from all diseases of the respiratory organs. Of the 11,865 deaths occurring during the month, 9,783 were reported from 149 cities, villages and larger towns, the aggregate death rate of which was 24.86 per 1,000 population.

FAKIRISM IN MEDICAL JOURNALISM.—A journal comes to our table with an editorial blast suggestive of Sinai. In trumpet tones, it announces that it is intended above everything, for the advancement of the broadest and highest principles of research and practice, in all the branches of medicine and surgery, and in all their allied sciences. It courts open, free and impartial discussion. Its aim is to furnish the profession, etc., etc. It does this work not for "filthy lucre," but for the love of it. It is engaged in the business of medical journalism for its health exclusively. Lastly, it excludes from its editorial, reading and advertising columns, everything which is not thoroughly scientific in its nature.

Did some one ask if this journal referred to, which carries upon its banner the word perfection, was a journal established by eminent men in the medical profession, so well endowed with this world's goods as to be entirely independent of income; by men whose every thought is in harmony with science, humanity, and up-building of the medical profession and the benefiting of every individual doctor in the world; by men not having to give a thought to the needful in a financial way, solely inspired by elemosynary desires; did this blast come from a medical journal established by such men? No. It came from a trade journal which sails under the name of medical journalism, and thus defrauds "Uncle Sam" of much money which properly belongs to him for postage. A trade journal published under the name of *Merck's Bulletin*, which is nothing more than a trade catalogue established for the purpose of presenting to the druggists and physicians of this country arguments in favor of drugs which are patented, and which happen to be completely controlled by the importing house of Merck & Company.—*Med. Mirror.*